Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

REAVIS REHAB & WELLNESS CENTER INC
1250 SOUTH AW GRIMES BLVD
ROUND ROCK TX 78664

Respondent Name
TPS JOINT SELF INS FUNDS

Carrier's Austin Representative
Box Number 11

MFDR Tracking Number
M4-13-1089-01

MFDR Date Received
JANUARY 2, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "No payment received."

Amount in Dispute per Table of Disputed Services: $1340.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2012	CPT Code 97110-GP (X4)	$188.56	$188.56
August 30, 2012	CPT Code 97110-GP (X3)	$141.42	$141.42
TOTAL		$1340.00	$329.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.600 effective July 1, 2012, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §134.600 effective May 2, 2006, requires preauthorization for specific treatments and services.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 198-Precertification/authorization exceeded.
   - 18-Duplicate claim/service.

   Neither party to this dispute submitted any explanation of benefits for date of service August 30, 2012. In accordance with 28 Texas Administrative Code §133.307(c)(2)(K), the Requestor has submitted convincing evidence of carrier receipt of the provider request for an EOB. Therefore, the disputed services rendered on this date will be reviewed in accordance with 28 Texas Administrative Code §134.203.

Issues

1. Does a preauthorization issue exist?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600(p)(5) requires preauthorization for physical therapy services.

   On the disputed dates of service, the requestor billed CPT code 97110 defined as "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility." The respondent denied payment based upon reason code "198."

   In support of their position, the requestor submitted preauthorization reports that support the following:

   - May 1, 2012, amended June 21, 2012 report from Injury Management Organization, (IMO), preauthorizing "12 sessions of Additional Physical Therapy to Right Femur/Ankle x 12 Visits at 3 times a week 4 weeks, up to 4 units per session to be done on an Outpatient basis."
   - Augut 28, 2012 report from IMO, preauthorizing "12 sessions of Additional Physical Therapy to Right Femur/Ankle x 12 Visits at 3 times a week 4 weeks, up to 4 units per session to be done on an Outpatient basis."

   Therefore, the requestor supported position that preauthorization was obtained and reimbursement is due.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2012 DWC conversion factor for this service is 54.86.

   The Medicare Conversion Factor is 34.0376

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 78664, which is located in Round Rock, Texas; therefore, the Medicare participating amount will be based on "Rest of Texas."

   The Medicare participating amount for code 97110 is $29.95.

   Using the above formula, the MAR is $47.14. The requestor billed for 7 units on the disputed dates; therefore, $47.14 X 7 = $329.98; This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $329.98.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $329.98 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/19/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.